State Retiree Health Benefits Program—Fact Sheet #2

Eligibility, Enrollment and Plan Choices

Who Is Eligible?

You are eligible to enroll in the State Retiree Health Benefits Program as a retiree if:

- You are a retiring State employee who is eligible for a monthly annuity from the Virginia Retirement System or a periodic benefit from one of the qualified Optional Retirement Plan (ORP) vendors, ***and***
- You are receiving (not deferring) your annuity or periodic benefit immediately upon retirement, ***and***
- Your last employer before retirement was the state, ***and***
- You were eligible for coverage as an active employee in the State Health Benefits Program up until your retirement date (not including Extended Coverage), ***and***
- **Within 31 days of your retirement date** you submit an Enrollment Form to your Benefits Administrator to enroll.

The only exceptions which allow for enrollment after 31 days from your retirement date are:

- State retirees who properly waived coverage as a retiree to enroll as a dependent on their spouse's active or retiree state health benefits membership may enroll in the retiree group within 31 days of the date that this coverage is lost. To document and preserve eligibility for the retiree group, these retirees should submit the waiver section of the enrollment form within 31 days of their retirement date.

- Certain involuntarily-terminated State employees with at least 20 years of creditable service who defer retirement may enroll at a later date (see your Benefits Administrator).

How Do I Enroll?

To assure a smooth transition from active employee coverage to retiree coverage, contact your agency Benefits Administrator three months before your retirement date to complete your enrollment form. Early enrollment will help to prevent problems during the transition from the active to the retiree program. **Remember--if you do not apply**

within 31 days after your retirement date, you will not have another opportunity to enroll. If you do not wish to enroll in retiree coverage, be sure to sign the "Cancel/Decline Coverage" portion of the enrollment form.

When Does Coverage Begin?

Coverage in the retiree group begins on the first day of the first full month of retirement if the retiree is eligible and enrolls within 31 days of his/her retirement date.

Who Is Not Eligible?

You are not eligible for the Retiree Health Benefits Program if:

- You do not meet the eligibility criteria listed previously;
- You decline coverage when you retire;
- You fail to submit an enrollment form to your Benefits Administrator within 31 days of your retirement date (you may also enroll using EmployeeDirect, an online enrollment system);
- You defer retirement when you leave State employment;*
  (Deferring retirement means that you will receive your retirement annuity at a later time, rather than directly after leaving eligible employment.)
- You cancel coverage at any time after enrollment.

**There are exceptions for certain involuntarily-terminated employees with 20 years of creditable service. See your Benefits Administrator for more information.*

What Types Of Coverage Are Offered?

The State Retiree Health Benefits Program is divided into two main retiree groups:

- Retirees and covered family members who are **not eligible for Medicare**, *and*
- Retirees and covered family members who are **eligible for Medicare**.

However, many retirees cover both Medicare and non-Medicare participants. If you are enrolled in Single or Two-Person coverage, each plan member must choose an appropriate Medicare or non-Medicare plan based on his or her Medicare eligibility status. That means that a retiree and a spouse, or a retiree and a covered child may have two different health plans. If that happens, each covered member will receive their own ID card with their own ID number. Family groups of three or more members (for example, a retiree plus two or more dependents with at least one Medicare-eligible member) may remain in the COVA Care non-Medicare Plan, but Medicare-eligible family members will continue to be covered by Medicare as the primary payer of their claims.

The ***Medicare and the State Retiree Health Benefits Program, Fact Sheet #5,*** is a good reference for more information about how your retiree benefits work with Medicare.

What Membership Types Are Available?

Your type of membership is determined by the number of persons enrolled based on your eligibility.

When you enroll, you will select the type of membership which best describes those you will be covering. The membership categories include:

- Single Coverage *(Retiree with or without Medicare)*
- Two people *(Retiree and one dependent, either of whom may have Medicare)*
- Family (*Retiree with two or more dependents, any of whom may have Medicare)*

Who Are My Eligible Dependents?

- The retiree's legal spouse.
- The retiree's unmarried biological or legally adopted children through the end of the year in which they reach age 23* as long as the child lives at home (except in cases when the child lives with the other parent if the retiree is divorced, or in cases where the child lives away from home while attending college or boarding school), and is eligible to be claimed on the parent's federal income tax return, or children placed in the home under a pre-adoptive agreement which is approved by the Department of Human Resource Management (DHRM).
- Unmarried stepchildren living full time with the retiree in a parent-child relationship who are claimed on the retiree's federal tax return.
- Adult children with a disability, if the qualifying disability was diagnosed prior to the loss of eligibility for coverage due to age and has been approved by the plan administrator. For the statewide self-funded plans, these children must be added within 31 days of loss of coverage. The regional, fully-insured plans require that the request be made prior to the time ineligibility for coverage due to age occurs.
- Other children on an exception basis. The child may be added only if a court orders the eligible employee/retiree to assume permanent custody of the child.

*Different eligibility criteria exist for certain survivors of retirees in the Retiree Health Benefits program. Please consult your Benefits Administrator for additional information.

Failure to remove ineligible dependents within 31 days of a loss-of-eligibility event may result in your suspension from the plan and/or retraction of claim payments as defined in the Administrative Code of Virginia.

How Do I Enroll My Disabled Dependent?

Eligible children may be covered beyond the normal limiting age if they are diagnosed with a qualifying disability prior to their loss of eligibility for coverage due to age. Application should be made to the self-funded plan administrator (Anthem Blue Cross and Blue Shield) within 31 days of the loss of coverage due to age. For coverage under a regional plan (Kaiser Permanente HMO), application must generally be made and approved by the carrier prior to the loss of coverage due to age.

The approval process is often time-consuming, and participants are encouraged to make application well before coverage terminates. If the application is approved, re-certification of the disability is generally required on an annual basis. If the adult disabled dependent later ceases to be disabled, it is the responsibility of the participant through whom eligibility is obtained to terminate the dependent's coverage within 31 days of the change in disability status to avoid coverage of an ineligible dependent. If the loss of eligibility occurs and is reported within 60 days of the end of the month in which the loss-of-eligibility event occurs, the dependent will be eligible to elect Extended Coverage per the provisions of the Public Health Service Act.

How Do I Choose A Plan?

If you are eligible and decide to enroll in the Retiree Health Benefits Program, you are required to choose a plan based upon whether you **are** or **are not** eligible for Medicare. The charts on the following pages show your plan choices.

Non-Medicare Plans

Plan Choices for Retirees and Dependents
Not Eligible for Medicare

Statewide Plans

- **COVA Care Basic**
- **COVA Care with Out-of-Network**
- **COVA Care with Expanded Dental**
- **COVA Care with Out-of-Network and Expanded Dental**
- **COVA Care with Vision, Hearing and Expanded Dental**
- **COVA Care with Out-of-Network, Vision, Hearing and Expanded Dental**

Regional Plan

Northern Virginia

- **Kaiser Permanente HMO***

**Kaiser plan members must 1) live in the Kaiser service area, and 2) select a primary care physician (PCP). Contact Kaiser for the specific cities and counties covered in their service area.*

Medicare Plans

Plan Choices for Retirees and Dependents Eligible for Medicare

Plans Offered by the Retiree Health Benefits Program

You may choose one of these plans:

- **Advantage 65***
- **Advantage 65 Plus Dental/Vision**

**You will be automatically enrolled in Advantage 65 when you turn 65; an enrollment form is required only if you wish to make a different selection. If you become eligible for Medicare before age 65, you must complete an Enrollment Form to enroll in a Medicare-coordinating plan immediately upon your Medicare eligibility.*

The following plans do not accept new enrollees and may only be selected by current enrollees:

- **Option I - Medicare Complementary**
- **Option II - Medicare Supplemental**
- **Option II with Dental/Vision**

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Plans Offered by Private Insurance Companies

- **Medigap Plans**

These are standard, supplemental insurance plans offered as individual policies that are designed to fill the gaps in Medicare Parts A and B coverage.

*If you choose a Medigap plan and cancel your retiree coverage, **you may not return** to the Retiree Health Benefits Program.*

Medicare Eligible Retirees -- Note To Option I And II Enrollees

Retirees currently enrolled in Medicare Complementary (Option I) and Medicare Supplemental (Option II) may continue enrollment in these plans. However, on July 1, 1997, these plans were replaced by the Advantage 65 plan, which combines features of both plans. Option I and II enrollees may elect to participate in the Advantage 65 plan prospectively at any time, but they may not re-enroll in Option I or Option II after electing Advantage 65.

For More Information About Medicare:

*More information about Medicare is available by going to the Medicare Web site at **www.medicare.gov** or by calling 1-800-MEDICARE.*